DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 9/10/12

PRINTED: 07/26/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445228	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	07/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF GREENEVILLE	725 CRUM STREET GREENEVILLE, TN 37743

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure corridor doors closed to a positive latch. (NFPA 101, 19-3.6.3.) The findings include: Observation and interview with the Maintenance Director, on July 24, 2012 at 10:00 a.m. confirmed the corridor door to the Birch hall clean linen room by room 21and the kitchen door to the employee break room failed to close to a positive latch. This finding was acknowledged by the	K 018	What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice: a) All facility maintenance personnel were immediately in-serviced on NFPA 101 Life Safety Code Standards. How you will identify other residents having the potential to be affected by the same defiant practice and what corrective action will be taken: a) All facility residents and visitors have the potential to be affected. What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur: a) All facility maintenance personnel were in-serviced on NFPA 101 Life Safety Code Standards on 7/24/12. b) The Maintenance Director, and/or the Maintenance Assistant will assure compliance through daily rounds to assure proper closure and positive latch of corridor doors. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; a) Maintenance Director, and/or the Maintenance Assistant, will make daily rounds to assure compliance and proper closure and positive latch of corridor doors. b) The Executive Director will assure compliance by making random daily rounds.	9/10/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Executive Director | (X6) DATE: 8/10/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 018	Continued From page 1 Administrator during the exit conference on July 24, 2012.	K 018	c) Results will be reported to the facility's Executive Director and reported monthly to the Performance Improvement Committee. d) The Performance Improvement Committee will review the results and; if deemed necessary by the committee, additional education may be provided. The process may be evaluated/ revised and/or the audits reviewed for 3 months or until 100% compliance is achieved. e) Performance Improvement Committee members are the Executive Director, the Medical Director, the Director of Nursing, the Assistant Director of Nursing, the MDS Coordinator, the PPS Nurse, the Rehab Service Manager, the Social Service Director, the Dietary Manager, the Pharmacist, the Maintenance Director, the Business Office Manager, the Housekeeping Supervisor, the Staff Development Coordinator and the Wound Care Nurse. .	
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure hazardous area ' s one (1) hour fire rated construction is maintained. The findings include: Observation and interview with the Maintenance Director, on July 24, 2012 at 9:10 a.m. confirmed unsealed penetrations in the following areas: 1) Conduit and cable lines in the ceiling of the FACP closet, 2) Sprinkler riser room ceiling, 3) Main electrical room, conduit above the Automatic Transfer Switch (ATS) was sealed with a non-approved fires top material (sheetrock mud). Based on observation and interview, the facility failed to assure rooms larger than 50 square feet, used to store combustible materials, were	**K029**	What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice: a) All facility maintenance personnel were immediately in-serviced on NFPA 101 Life Safety Code Standards. b) All penetration areas listed have been sealed with fire rated caulk on 7/24/12. c) Door closer placed on emergency supply room door in kitchen on7/24/12. d) Dry goods storage room door has been ordered 8/10/12 and will be installed upon arrival.	**9/10/12**

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K 029	Continued From page 2 provided with door closers. The findings include: Observation and interview with the Maintenance Director, on July 24, 2012 at 10:15 a.m. confirmed the kitchen emergency supply room was not provided with a door closer (NFPA 101, 19.3.2.1 (7) and the dry goods storage room was not provided with a door as shown on the building drawings. These findings were verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on July 24, 2012.	K 029	How you will identify other residents having the potential to be affected by the same defiant practice and what corrective action will be taken: a) All facility residents and visitors have the potential to be affected. What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur: a) All facility maintenance personnel were in-serviced on NFPA 101 Life Safety Code Standards on 7/24/12. b) 100% of facility was checked and no further areas of concern were found. c) The Maintenance Director, and/or the Maintenance Assistant, will make random rounds to monitor daily compliance. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: a) The Maintenance Director, and/or the Maintenance Assistant, will make rounds to monitor daily compliance. b) The Executive Director will assure compliance by making daily random rounds. c) Results will be reported to the facility's Executive Director and reported monthly to the Performance Improvement Committee. d) The Performance Improvement Committee will review the results and; if deemed necessary by the committee, additional education may be provided. The process may be evaluated/ revised and/or the audits reviewed for 3 months or until 100% compliance is achieved.	
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure all areas with exterior roofs were sprinkled (NFPA 13, 8.14.7.1.) The findings include:			

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K 056	Continued From page 3 Observation and interview with the Maintenance Director on July 24, 2012 at 11:30 a.m. confirmed the alcove at the electrical room was not provided with sprinkler protection. This finding was acknowledged by the Administrator during the exit conference on July 24, 2012.		e) Performance Improvement Committee members are the Executive Director, the Medical Director, the Director of Nursing, the Assistant Director of Nursing, the MDS Coordinator, the PPS Nurse, the Rehab Service Manager, the Social Service Director, the Dietary Manager, the Pharmacist, the Maintenance Director, the Business Office Manager, the Housekeeping Supervisor, the Staff Development Coordinator and the Wound Care Nurse. .	
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure that fire hydrants were accessible. The findings include: Observation and record with the Maintenance Director, on July 24, 2012 at 11:00 a.m. confirmed the fire hydrant in front of the building was not clearly visible and was obstructed for fire department access by landscaping. This finding was acknowledged by the Administrator during the exit conference on July 24, 2012.	K056	What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice: a) Facility Maintenance personnel were immediately in-serviced on NFPA 101 Life Safety Code Standards. b) Exterior alcove sprinkler head installed 8/9/12. How you will identify other residents having the potential to be affected by the same defiant practice and what corrective action will be taken: a) All facility residents and visitors have the potential to be affected. What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur: a) All facility maintenance personnel were in-serviced on 7/24/12 on NFPA 101 Life Safety Code Standards. b) The Maintenance Director, and /or the Maintenance Assistant, will make random rounds to monitor daily compliance.	9/10/12

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K 056	Continued From page 3 Observation and interview with the Maintenance Director on July 24, 2012 at 11:30 a.m. confirmed the alcove at the electrical room was not provided with sprinkler protection. This finding was acknowledged by the Administrator during the exit conference on July 24, 2012.		How the corrective action(s) will be monitored to ensure the deficient practice will not recur: a) Maintenance Director, and/or the Maintenance Assistant, will make rounds to monitor daily compliance and to assure the sprinkler system is maintained. b) The Executive Director will assure compliance by making random daily rounds. c) Results will be reported to the facility's Executive Director and reported monthly to the Performance Improvement Committee. d) The Performance Improvement Committee will review the results and; if deemed necessary by the committee, additional education may be provided. The process may be evaluated/ revised and/or the audits reviewed for 3 months or until 100% compliance is achieved. e) Performance Improvement Committee members are the Executive Director, the Medical Director, the Director of Nursing, the Assistant Director of Nursing, the MDS Coordinator, the PPS Nurse, the Rehab Service Manager, the Social Service Director, the Dietary Manager, the Pharmacist, the Maintenance Director, the Business Office Manager, the Housekeeping Supervisor, the Staff Development Coordinator and the Wound Care Nurse. .	
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure that fire hydrants were accessible. The findings include: Observation and record with the Maintenance Director, on July 24, 2012 at 11:00 a.m. confirmed the fire hydrant in front of the building was not clearly visible and was obstructed for fire department access by landscaping. This finding was acknowledged by the Administrator during the exit conference on July 24, 2012.			

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